Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS503S	A. BUILDING _____ B. WING _____	C 12/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF GREEN VALLEY	100 DELMAR GARDENS DRIVE HENDERSON, NV 89014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments Surveyor: 27469 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 12/3/09 and finalized on 12/9/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00023758 was substantiated with deficiencies. Please refer to Tag S230 Complaint #NV00023783 was substantiated with deficiencies. Please refer to Tag S230 Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	Z 000		
Z230 SS=E	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z230	Continued From page 1 comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Surveyor: 27469 Based on interview and record review, the facility failed to ensure that urethral bleeding and clots were accurately assessed, that a Foley catheter was removed in accordance with professional standards of practice, and that nursing staff accurately documented assessments and actions related to the care of a Foley catheter for 1 of 4 residents (Resident #1). Based on interview and record review, the facility failed to ensure staff utilizied the appropriate resources for an emergency transfer to an acute care facility for 1 of 4 residents (Resident #4). As a result the call for the emergency transport was delayed. Severity: 2 Scope: 2	Z230		